Dental

Frequently Asked Questions

If I start to see Medicaid patients, can I put a limit on how many I see or can I stop taking Medicaid at any time?

Dental Providers do not have to accept Medicaid even if enrolled in CHAMPS. It is up to the Dental Provider when they see Medicaid beneficiaries. If you do not want to participate in Medicaid anymore, you can request your enrollment be end dated at any time. Note: If you wish to still provide dental services for Managed Care Organizations (i.e., Medicaid Health Plan or Integrated Care Organization) your CHAMPS enrollment will need to stay active.

If I was enrolled in CHAMPS years ago, am I still enrolled?

Yes, but your enrollment status is inactive. If you were enrolled in CHAMPS at one time, then your enrollment is still in CHAMPS, and you would need to log back into CHAMPS, make the applicable updates, and resubmit your enrollment application. Once approved you may begin billing for service.

If I do not want to accept Medicaid Fee-For-Service and only want to participate with certain dental vendors who are contracted through a Managed Care Organization such as Delta or DentaQuest, do I still need to enroll in CHAMPS?

Yes, providers need to enroll in CHAMPS. It is also important to follow up with the Managed Care Organization to make sure you are credentialed. (Dental Responsibilities at a Glance)

If I currently accept Healthy Kids Dental (i.e., Delta Dental and DentaQuest), can I start seeing Medicaid adults?

Dental Providers will need to log into CHAMPS to confirm their CHAMPS enrollment allows for direct billing to CHAMPS; meaning you are enrolled as an Individual/Sole Proprietor, Facility/Agency/Organization (FAO), or Group Enrollment Type OR enrolled as a Rendering/Servicing AND associated to a billing provider with an enrollment type of Individual/Sole Proprietor, Facility/Agency/Organization (FAO), or Group. Dental Providers who are enrolled as a Rendering/Servicing provider and only associated to Delta Dental or DentaQuest cannot submit Medicaid Adult dental claims. It is also important to follow up with a Managed Care Organization to make sure you are credentialed if you wish to see patients in a Medicaid Health Plan or Integrated Care Organization. (Dental Responsibilities at a Glance)

I have billed dental services to a Managed Care Organization (i.e., Medicaid Health Plan or Integrated Care Organization) and have not received the updated dental service rates.

The increase for Managed Care Organizations Dental fee screen rates for Medicaid became effective on April 1st, 2023, rather than January 1st, 2023, as in the case of Medicaid Fee-For-Service. We kindly ask that you give the plans sufficient time to process this change.

What is the difference between Medicaid, Fee-for-Service, Medicaid Health Plan, Integrated Care Organization, and Managed Care Organization?

Medicaid is a health care program for low-income families and individuals of all ages. In Michigan, there is traditional Medicaid and the Healthy Michigan Plan (HMP). Eligible beneficiaries can then enroll in a Medicaid Health Plan (MHP) or an Integrated Care Organization (ICO). Within the Medicaid population, there are groups that:

- Must enroll in an MHP.
- May voluntarily enroll in an MHP or ICO.
- May be passively assigned to an ICO.
- Are excluded from enrollment in an MHP or an ICO.

Medicaid Health Plan (MHP): A Medicaid-managed care plan that provides medical assistance through the delivery of Covered Services to Beneficiaries and that holds a Comprehensive Health Care Program Contract with the State of Michigan.

Integrated Care Organization (ICO): A Medicare-Medicaid managed care plan that operates under a three-way contract with MDHHS (Medicaid) and CMS to provide all Medicare and most Medicaid covered services through a program called MI Health Link that integrates into a single coordinated delivery system all physical health care (including dental and vision), pharmacy, long term supports and services, Home and Community Based Services (HCBS), and Medicare behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid. (Medicaid Specialty Behavioral Health Services are carved out and provided by regional PIHPs.)

Managed Care Organization (MCO): Encompasses all MDHHS contracts where a monthly capitation rate is given to provide specific covered services to enrolled Medicaid beneficiaries (i.e., MHP and ICO).

How do I see the dental fee screens for Medicaid?

Medicaid fee screens are located at www.Michigan.gov/MedicaidProviders >> Billing & Reimbursement >> Provider Specific Information >> Locate Dental

Are there any restrictions on capping the amount of Medicaid fee-for-service beneficiaries a provider sees?

Enrollment in Medicaid does not legally require a provider to render services to every Medicaid beneficiary seeking care, except as noted below. Providers may accept Medicaid beneficiaries on a selective basis. However, a Medicare participating provider must accept assignments for Medicare and Medicaid dual eligibles.

If a Medicaid-only beneficiary is told and understands that a provider is not accepting them as a Medicaid patient and asks to be private pay, the provider may charge the patient for services rendered. The beneficiary must be advised prior to services being rendered that their mihealth card is not accepted and that they are responsible for payment. Providers should maintain a specific, written agreement signed by the beneficiary in the beneficiary's file. The standard agreement that the beneficiary is responsible if insurance does not pay does not apply to Medicaid beneficiaries. Providers are not to bill Medicaid for any portion of a service for which they are already billing a patient due to not accepting them as a Medicaid beneficiary.

When can a beneficiary change their health plan?

The majority of Medicaid Beneficiaries are required to enroll in a Medicaid Health Plan. Beneficiaries who are required or are eligible to enroll in a health plan have the opportunity to choose their health plan. They are given a pamphlet, "Choosing Your Health Plan", which provides them with information on this process. If no selection is made, the beneficiary is automatically enrolled with a health plan in the beneficiary's county of residence. The beneficiary has 90 days after the assignment of or choosing a health plan to change the health plan. After 90 days, the beneficiary is required to remain in the chosen health plan until the next open enrollment period. Individual open enrollment periods are based on the last digit of the case number associated with the Medicaid coverage. (1=January, 2=February, etc.) Questions about whether a patient is eligible for a health plan change should be directed to call the Beneficiary Help Line at 800-642-3195.

Who should I contact for Prior Authorization when a beneficiary is in a Managed Care Organization (i.e., Medicaid Health Plan or Integrated Care Organization)?

If a beneficiary is under the care of a Managed Care Organization, such as a Medicaid Health Plan or Integrated Care Organization, healthcare providers must reach out to the organization in charge of the beneficiary's care to obtain prior authorization requirements. To confirm the beneficiary's eligibility, please use the CHAMPS Eligibility Verification Inquiry tool.

What is the best practice for verifying beneficiary eligibility?

Dental providers must verify beneficiary eligibility using the CHAMPS Eligibility Inquiry and/or a vendor that receives eligibility data from CHAMPS prior to rendering services. Providers may verify beneficiary eligibility using:

- CHAMPS Eligibility Inquiry
- HIPAA 270/271 (Eligibility Inquiry/Response) transactions
- Web-based options

What happens if I bill for a non-covered service?

If a service is non-covered the only way FFS Medicaid would reimburse on the code is when the beneficiary is dually enrolled in Medicaid and Medicare and Medicare made a payment. Also, as a reminder, a beneficiary cannot be charged for noncovered services unless an agreement was signed prior to rendering the services.

Where do I access more information about the CHAMPS Provider Enrollment Application process?

Details regarding provider enrollment can be found in the Michigan Medicaid Provider Manual, General Information for Providers Chapter, Section 2 Provider Enrollment or for step-by-step instructions visit www.Michigan.gov/MedicaidProviders >> Provider Enrollment

What is the frequency coverage for crowns, endo, etc.?

For Crowns, the frequency is 1 per 5 years per tooth. For any additional services, you can go to the Medicaid Code and Rate Reference Tool within the External Links of CHAMPS. Once there click on the Reports Tab and then Dental. Once you select dental you can download the dental

fee screens with the limits included. You will notice some of the codes will state CSHCS ONLY which means that the service is only covered and paid for those beneficiaries with CSHCS. CSHCS Only services (enhanced dental services) are billed to FFS, not the health plan. Not all CSHCS beneficiaries automatically qualify for these services.

Is there a reference document that lists who the payer is for dental services for each health plan, etc.?

The Dental Responsibilities at a Glance as of April 2023 document has each Medicaid Health Plan and Integrated Care Organization broken down including their dental vendor and phone number.

Where do we send Prior Authorizations and Frequency Verifications?

Medicaid beneficiaries not in a MHP or ICO can send Dental Frequency Verifications to ProviderSupport@michigan.gov. For Medicaid beneficiaries not in a MHP or ICO, requests for PA (except pharmacy) may be submitted in writing, via Direct Data Entry (DDE) through CHAMPS, or electronically (utilizing the ASC X12N 278 5010 Health Care Services Review/Request transaction) if the provider is an MDHHS-approved EDI submitter.

What dental services are covered?

- X-rays
- Teeth Cleaning Prophies
- Restorations
- Extractions
- Dentures
- Sealants (new)
- Endodontics (new)
- Crowns (new)
- Periodontal Therapy (new)

Do the Managed Care Organizations (i.e., Medicaid Health Plan or Integrated Care Organization) have to follow the new dental policy changes?

Medicaid dental policy MMP 23-13 is only applicable to Medicaid (traditional) fee-for-service. Nevertheless, Michigan's Managed Care Organizations (i.e., Medicaid Health Plans or Integrated Care Organizations) must operate consistently with all applicable published Medicaid coverage and limitation policies. MHPs and ICOs may choose to provide services over and above those specified. MHPs and ICOs are also allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements.

If a PA change request is needed, do I have to resubmit a prior authorization form MSA 1680-B with supporting documentation?

No. Providers only need to submit a modification to the original approved prior authorization letter and on the cover letter write "CHANGE REQUEST". A Program Review analyst may follow up to request an updated tooth chart in order to approve the change.

When looking in the Michigan Medicaid Provider Manual I do not see any policy updates regarding MMP 23-13?

The Michigan Medicaid Provider Manual is updated quarterly and will reflect all policy changes come July 2023. Reference dental policy MMP 23-13 until updates are made.